Research

Highlanders: a qualitative study to explore the experiences of home care nurses in rural areas in Italy

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Abstract

Introduction and aim: Home care in rural areas is characterised by peculiarities linked to both the type of care of the patient and his/her family and the context in which it is provided. International studies have highlighted the need for specialised training and advanced clinical skills to work in this field. Currently, there are no studies in the literature that explore the experiential feelings of Italian nurses who provide home care in rural areas.

Setting: Rural areas in Italian Apennine District.

Participants: Italian home care nurses in the selected areas.

Design: Qualitative study using a transcendental phenomenological approach. Semi-structured interviews were conducted face-to-face, and audio was recorded with home care nurses.

Results: Eleven nurses (mean age, 53 years) were interviewed. Four themes supported by nine codes emerged: "Entering your homes" (Stepping lightly; a matter of trust; key professional); "Being home care nurses in rural areas"

(Working alone, autonomy, responsibility and gratifications; ideal characteristics of home care nurse); "Love and hate toward doctors" (Family doctors; ANT doctors); "The territory: the Apennines and mountainous areas" (working in rural areas; healthcare professionals).
Discussion and conclusions: The risks for home careers in rural areas are related to the vastness of the territory, long car journeys, the harsh climate in winter, and pets in the homes. The beauty of the area, the close relationship established with the families in charge, and daytime working hours are reasons for great professional and personal satisfaction. Some modalities and forms of collaboration with general practitioners can be improved.

Keywords: Nurse, Home Care, Rural-Mountainous Areas, Perceptions, Criticality, Satisfaction

Introduction

Ensuring healthcare services to populations living in mountainous and hard-to-reach areas (rural zones) remains a global healthcare[1–4]. In Italy, community-based healthcare is a fundamental pillar for meeting citizens' needs adequately, even during the COVID-19 pandemic [5]. The Domiciliary Nursing Service (DNS) delivers healthcare, provides health education, and ensures a continuum of care with attention to social aspects[6–8]. Nursing care is built on interpersonal relationships characterised by dialogue, listening, humanisation, and respect [9–11]. Nurses working in rural areas often belong to small working groups[8], in contrast to urban or city settings, and they frequently feel isolated from the rest of the healthcare system[1,3,4].

In different parts of the world, nurses working in rural areas must consider geographical factors, population density, and community needs[4]. These nurses, including Family Nurse Practitioners and Family Health Nurses, have advanced clinical skills and produce outcomes on par with those of the general practitioners[4]. They often work in unique, highly complex, and sometimes hazardous settings to provide essential health care services to communities[11]. Professionals choosing to specialise in this clinical setting are drawn by elements such as a high degree of professional autonomy, the ability to provide ongoing care to a small group of patients, ensuring continuity of care (case management), high economic remuneration, and the opportunity to live in the natural beauty of the environment in which they work [12]. Several studies have emphasised the positive impact of advanced practice nurses on rural populations, particularly in areas with a shortage of general practitioners[13,14].

Even within Italy, there are challenging territorial contexts, such as rural areas, where home care services are extensively employed to reach the population living in these geographical zones.

In the Emilia-Romagna Region of Italy, the network of community services is organised into Primary Health Care Departments, which encompass all the necessary services for the local population. The Domiciliary Nursing Service (DNS) is part of these departments and consists of home care nurses who provide care to patients in their homes.

Therefore, this study aimed to explore the experiences of home care nurses working in an Italian rural district to understand the characteristics that define them, their perceptions, levels of satisfaction, difficulties, and competencies.

Materials and methods

Study design and data collection

To answer the question "What are the experiential feelings of nurses serving in rural areas in Italy?" a transcendental phenomenological qualitative study was conducted[15,16]. This approach aims to understand the everyday life experiences of individuals–that is, how these experiences are lived and what they mean. Researchers seek to uncover the essence of a given phenomenon, the basic underlying structure that remains constant from one experience to another, while also acknowledging

individual differences and remaining open to experiential elements that go beyond what is verbally expressed and thus conscious[15–17].

For data collection, semi structured interviews were conducted

face-to-face and audio recordings were recorded using a voice recorder. The photo-dialogue technique was adopted to allow triangulation of the data. Then, during the weeks leading up to the interview, the nurses recruited into the study were asked via explanatory email to take one or more photographs subjectively portraying the essence of their work. The pictures were analysed, and their interpretation was discussed on the day of the interview, beginning with an in-depth description of the subjective work experience. In fact, photos can be the synthesis of concepts that might be difficult for some subjects to express through traditional communication channels, such as speech and writing. This technique was chosen because the image can synthesise stories, emotions, and ideas. In addition, it is a technique that encourages input into storytelling[2,17,19,21,22].

During all the interviews, based on the experiences touched upon by the individual at the moment, and using open question ("Working in the territory of the Apennines...") and some key-words based questions as a cue for the narration ("Difficulties related to working in this territory..."; "Living in the same (mountain) territory where you work..."; ' Leisure time (with this kind of work)..."), the participants lived perceptions were explored.

Questions were asked in a way that maximised each participant's free expression and were posed in such a way as to achieve exploration of the whole experience (working in a mountainous area, but also potential difficulties and alternation between work and leisure in small mountain communities).

During the interview, the researcher took notes and observed the congruence between what the participant stated and his or her nonverbal attitude (posture, facial expressions, tone of voice, emphasis given to expressions, etc.) and the presence or absence of behavioural manifestations of discomfort, excessive stress, or anxiety with respect to the precise moment. At the end of each interview, the researcher reiterated the aspects expressed by the individual to confirm emerging elements [20,22].

No management software was used for the analysis of the narrative data, but each individual interview was read several times idependently by the researchers: first readings to obtain a general understanding of the phenomenon and numerous minute readings of each interview to extrapolate the most significant sentences. The most significant sentences (quotes) were assigned codes that briefly identified the meaning of the quote. The codes were grouped into themes based on their meaning and relationships. Each theme was deepened and supported using two or three codes .. All interviews were conducted by the first author, NC (RN, MSN), a male nurse with experience in qualitative research, and acquired through 60 hours of specific theoretical and practical training (including simulations). The interviewer was an operating nurse working at the high care unit in a hospital within the Local Health Authority of Bologna (Emilia Romagna) who had no prior knowledge or relationships with the interviewees. The participants were informed that they could interrupt the interview at any time. The interviews were conducted in an environment with adequate privacy and atmosphere of respect.

Sample, setting and modalities

Semi-structured interviews were conducted with home care nurses operating within an Italian Apennine district chosen based on logistical criteria. One of the authors conducted the interviews in August 2021. There were four locations within the Apennine District (clinics and Offices of the Domiciliary Nursing Service) from which participants were recruited and where the interviews took place.

Propositional sampling was performed[17-21].

The nurses were enrolled if they were actively working at the Domiciliary Nursing Service within the Apennine District, had worked in the Domiciliary Nursing Service for more than three months, and had expressed their consent to participate in the survey.

22 nurses were included, none of whom refused to participate in the study. Nurses with great professional experience in home care in mountainous areas participated in this study.

The first author (the interviewer) contacted each nurse who had given his/her availability to participate in the study by e-mail and then telephone. This was performed in accordance with personal and professional commitments. The nurse coordinator accompanied the

researcher to the interview location on each occasion, introducing the interviewer to the nursing staff and thus contributing to a climate conducive to dialogue and freedom of expression among colleagues. At the beginning of each interview, the researcher explained the purpose of the study and his role as an interviewer and then invited the person to introduce himself. All interviews (except one) were conducted using the subject's description of a photograph. During the interviews, the researcher dressed in informal clothes and expressed an attitude of courtesy and respect. During the interviews, he paid special attention to the nonverbal attitudes of the participants to catch any expression/manifestation of discomfort and/or closure. No other person was present, in addition to the researcher and interviewee during the interview.

Data Analysis and Methodological Rigor

Narrative data were analysed using the Colaizzi Method (1978)[20–24]. The analysis involved initial coding, code category creation, and definition of emerging themes.

To ensure methodological rigour (reliability, credibility, and transferability), the following elements were observed in this study:

- Implementation of bracketing or "judgment suspension"[16–18,20–22]. Researchers became aware of any preconceptions and knowledge they held regarding the research topic and wrote them down in a notebook to help deactivate expectations and avoid influencing the research with their own biases, stereotypes, and/or preconceptions.;
- The recruitment of nurses to be interviewed until data saturation[18,20–22]. Nurses were enrolled until each recruited interviewee no longer provided new information. Data saturation was reached by the seventh interview, but the researchers decided to continue enrolment for an additional 4 subjects. The researchers decided to end data collection at the 11th interview because no new information emerged.
- Conducting member checking for result validation[18,20–22]. The final data processing was shown individually to each participant, approximately one month after the end of the interviews. All participants agreed with the themes that emerged and the related codes and made no corrections or additions. Performing code and recode procedures [18,20–22]. An initial coding of the data was performed, and after two weeks a new coding was performed. The results of each coding were then compared. This allowed the data to be extrapolated with greater reliability, reducing the risk of missing important information that emerged during interviews.
- Data triangulation[18,20–22]. To validate the collected information, interviews and photographs represented different sources of the same data[25,26].
- Researcher triangulation (or peer review)[18,20–22]. Data analysis and coding were conducted separately by each researcher and were subsequently compared.
- Implementation of an audit trail[27]. An external researcher, unaffiliated with the study, reconstructed the process, shared the rationale for the decisions made, and obtained the same results.

Ethical Aspects

Authorisation was obtained from the relevant Local Health Authority and written consent was obtained from all participants before conducting the interviews. To maintain confidentiality, each transcribed interview was assigned a numerical code to ensure that only the interviewer knew the interviewee's identity. Other researchers involved in the data management and analysis were blinded to the participants' identities. All narrative data and photographs were stored in a database that was accessible only to researchers. The investigation adhered to the confidentiality parameters outlined in Article 13 of the Italian Legislative Decree 30 June 2003 No. 196, and its subsequent amendments and additions.

Results

Socio-Demographic Characteristics of Participants

Eleven nurses were interviewed out of a total of 22 participants (including two males), with a mean age of 53 years. The average interview duration was 50 minutes (range=30-80). None of the nurses had received post-basic training in community healthcare. Their previous work experiences before transitioning to community services were diverse, ranging from emergency medical systems and emergency departments to medicine and surgery wards, intensive care units, and operating rooms.

The nurses were willing to be open to dialogue

and no manifestation of discomfort was perceived. Therefore, no interviews needed to be repeated or deepened.

Themes Emerging from the Interviews

Table 1 summarises the themes that emerged during the interviews along with their corresponding codes. The emerging themes and the codes that support them are presented below. Quote excerpts were provided for each code to ensure reliability.

Table 1. Themes and Related Codes.

Theme	Code
Entering your homes	- Stepping lightly - A matter of trust - Key professional
Being home care nurses in rural areas	- Working alone, autonomy, responsability, and gratifications - Ideal characteristics of home care nurse
Love/hate doctors	- Family doctors - ANT doctors
The territory: the Apennines and mountainous areas	- Working in rural areas - Healthcare professionals

Legend. ANT-Associazione Nazionale Tumori (National Cancer Association, a non-profit foundation for specialized home care)

Theme 1: Entering Your Homes

Healthcare professionals visit patients in their homes, bringing their expertise and moving away from the primary place of care and work, which is commonly associated with hospitals in the collective imagination.

Crossing the threshold of someone else's home has deep significance. This means entering people's intimacy, being welcomed, for better or worse, into their living space, and becoming guests. Respect, delicacy, and calmness are necessary when entering homes, "**stepping lightly**", to gain people's trust and become a significant point of reference for the entire family. Respect and gradualness are essential elements to earn the trust of patients and their families: "We must enter homes quietly, with respect and tranquility. [...] Some mountain people, because they used to be more reserved, have difficulty opening up and fully opening the door. At first, they crack the door open, and over time, they let you in..." (interview 1). Home is a special place of care that represents a very intimate part of people's lives. When admitted, there is a sign of privilege and distinction. Home nurses must demonstrate their abilities, earning the trust of everyone present in the home to be accepted and respected as a professional ("**a matter of trust**"). Trust is not instinctual, but a process of becoming familiar, exposing oneself, sharing, and assessing others' loyalty. Trust exists only when there is reciprocity among colleagues, between nurses and patients, and between nurses and doctors: '[...] first, you have to get to know the patient and their family circle a bit, to be able to trust, even blindly, the family and the environment around them. [...] You begin to establish good relationships, especially with great mutual trust... So, the difference between the ward and home is certainly the relationship that is established with the patient and their entire family." (interview 1); "[...] the doctor must trust, trust what you say based on your assessment!" (interview 3). An interesting aspect that emerged is related to having confidence in oneself: "It's also very important how you present yourself to others; you have to show that you have confidence in yourself first, that you know exactly what you have to do [...] so that people have confidence in you" (interview 5).

The home nurse is the "**key professional**" for the entire family: "You are a distinct figure for the population you serve in the community. There is a doctor, but there is also a home nurse for the people you can assist. You are a point of reference and are recognised by the community as a professional." (interview 9). This responsibility inevitably requires comprehensive care, both for the patient and the family: "[...] when I have time, I ask them to tell me about their life, their experiences, and their history. This helps me better understand the people I care for. It is

very useful. Empathising with the patient and providing total and holistic care '(Interview 11);' [...] you have to take complete care of them. [...] We are also all case managers. [...]" (Interview 8).

Being a reference point for patients across the vast Apennine territory can be exhausting, particularly from an emotional perspective. Following their patients for a long time can be a drawback because the relationships that develop with patients and their families are profound and characterised by continuity that lasts for many years. Additionally, all the interviewed nurses lived in the Apennine region where they worked. Many of them have provided home care in the same area where they live, and some still do so. For most, this is considered a negative factor, and some have specifically requested transfer and now work in a different district far from their homes: "I feel really bad about this. Working in the same place where you live is very burdensome [...] There is a positive side where you know the area, most roads, and even the most remote places. But the negative side is that you know everyone, people know you, and sometimes they judge you before knowing what kind of professional you are..." (interview 3); "[...] I often assist relatives and friends, even dear friends [...]" (Interview 8). One nurse, however, finds it stimulating to care for and provide support to people she knows: "I feel that some colleagues complain because they say it is heavy to work where you live, but it is a matter of character. It has not bothered me. It can even be more stimulating to care for people you know and who live nearby" (interview 6). Being a point of reference for the community is flattering for nurses.

Theme 2: Being Home Care Nurses in Rural Areas

The home care work takes place in a setting that is not "protected" like the hospital environment, and certainly not designed for healthcare professionals. Patients' homes and the external environment pose challenges for nurses who perform a dynamic and sometimes "adventurous" job. Faced with difficulties, they employ numerous skills and develop new abilities, particularly adaptability to find creative solutions to problems and work effectively even when essential tools are lacking, outside of the ideal setting: "It also requires a lot of adaptability, and not everyone has it. A urinary catheter was inserted while kneeling the patient on a double bed. Alternatively, we have attached an IV to a ladder, a coat rack, or even a nail where there used to be an image of the Holy Mary." (interview 6).

Furthermore, work is characterised by a high degree of professional autonomy and responsibility. When a home nurse is at a patient's home, she is alone. This aspect of home care has frightened several colleagues. They must be competent, confident in their abilities, act promptly and accurately, and often be in front of a group of family members. Usually, they cannot ask for help from anyone except in rare cases. Working alone provides the opportunity for the professional to become the primary caregiver for the patient, with great personal satisfaction and responsibility. The first code of this theme is, therefore, "**working alone, autonomy, responsibility, and gratifications**": "I come from the hospital ward, and I know well that the ward has its positive sides. One is that you are never alone. [...] Working alone is a part of home nursing. It is wonderful, but it is also very scary. You have no one; you are there alone, and there is no doctor. But at the same time, you have great personal satisfaction because if you succeed, you are happy and say 'I did it.' There is esteem and recognition that patients and their families show you. This is the most beautiful part" (Interview 1). Unlike hospital wards, in certain moments, home nurses, precisely because they are completely alone, must make very delicate decisions: "[...] I took on huge responsibility. [...] Sometimes, driven by desperation, we take on enormous responsibilities..." (interview 1).

All nurses talked during the interviews about the autonomy they had in the community, contrasting it with their experiences in the hospital. For the sake of the patient, community nurses take on many clinical responsibilities because they understand the sensitivity of certain conditions and act immediately to prevent any deterioration: "This makes your work as a nurse much more demanding in terms of responsibility and initiative." (interview 2); "To get city nurses to take on responsibilities is very difficult. They just do not want to! However, we do everything [...]. Perhaps we take too many risks; in the city, they take too few risks, they are always on the defensive' (interview 8). Despite the many responsibilities, home nursing is gratifying and brings numerous personal and professional satisfaction to nurses, especially because of their gratitude people show them.

The interviewees repeatedly emphasized what the "**ideal characteristics of home care**

nurse" should be, such as the need to have prior experience in other care settings: "You also need to be very skilled and have experience." (interview 10). Sometimes, they must identify new health problems without the support of medical personnel. Practical skills are essential, and actions and techniques learned over the years through extensive practice. These skills are acquired in specialised wards and then used in patients' homes: "The first years of work shape you as a nurse. It is not right to send someone who has just graduated from the community, because you are still alone, have no references, and are a bit lost. [...] You need to have experience in the hospital... The community comes later...' (Interview 9). Nurses must possess excellent adaptability because they have to deal with every situation, trying to find solutions with the resources available in their backpacks and bags: "We have to adapt a lot in home care... Sometimes we do treatments in absurd places and positions...' (interview 2); "It's not good to work in rigid compartments; you have to be open-minded. You have to adapt and solve problems creatively..." (interview 5); "Certainly, we are not all the same, and not everyone is suitable for working in the community. I have seen many coming and going. Some ran away in despair' (Interview 6). Collaborating with other professionals is crucial and allows for personal and professional enrichment: "You have to collaborate and interact." (interview 3); "You still need to know how to work in a team. You must create a good working group. You have to create a family, even in the workplace' (interview 6).

Another essential aspect is the physical fitness that these nurses must possess, because their work is extremely physically demanding. Their bodies are continually exposed to the elements and temperature changes because, as they move from one home to another in their cars, they fully experience the weather conditions and seasonal changes. Additionally, driving for many hours is tiring, especially on mountain roads that often have potholes and numerous curves along the way. Backpacks and bags, which contain everything they need, are heavy to carry. They all agree that they need young nurses with good physical fitness, without health problems, and who are athletic and resistant. I believe that we need young, willing, strong, and experienced nurses from various care settings. Let us stop sending old people to home care, as they cannot handle it physically! ... Young, healthy, fit, and motivated individuals" (interview 3); "[...] This is because they are physically demanding jobs. It is not just about taking blood samples; sometimes you do things in absurd positions. You do not have hospital beds; sometimes, you have to insert a urinary catheter and find yourself in bed with the patients! Kneeling to perform dressing..." (interview 10).

Theme 3: Love/hate doctors

From the interviews, the importance of multiprofessional collaboration in achieving a common goal became evident. It is essential for home-care nurses to collaborate with medical personnel. For some, nurses and doctors are two sides of the same coin; their work is so closely intertwined that it is almost inseparable.

Regarding primary care doctors, commonly known as "**family doctors**", in everyday language, some interviewees expressed a harsh tone and a somewhat negative view of the medical component. Being at a patient's home, knowing what needs to be done but not being able to act because the doctor is not immediately available, can be very challenging for home nurses, who often do not answer their phones or have them turned off. It's difficult. If you are at a patient's home and they are unwell, you want to consult with their primary care doctor [...]. Sometimes colleagues are forced to call the emergency medical system [...]." (interview 1).

However, there are cases of good collaboration and a shared focus on the same goals:' We work a lot with primary care doctors. To the best of our knowledge, this relationship is very good. Then, as in all things, it depends on the doctor..." (interview 9). One nurse raised a particularly important issue, which concerns the retirement of many primary care doctors in the Apennine region who have not yet been completely replaced. The Apennine Mountains seem unattractive to young doctors, and the difficulties in finding substitute personnel are enormous. In Italy, this shortage likely led to the emergence of associations that provide home care. The relationship that home nurses establish with doctors from the National Tumor Association (ANT) involves full collaboration and respect. All nurses shared the same opinion about the "**ANT doctors**" with whom they collaborated, describing them as excellent healthcare professionals, capable, and humane. They often find themselves assisting patients at home while coordinating with them: "One of our

fortunes is having Dr. [name of the doctor] who oversees all the cancer patients taken care of by the ANT. Without her, we would be very difficult […]. Terminally ill cancer patients are in high demand because of the narcotic drugs used for sedation, placing elastomers, and many more. Without ANT, they would all die in the hospital, overwhelming the wards. […]." (interview 2).

Theme 4: The Territory - The Apennines and Mountain Areas

The Apennine district is characterised by its vast expanse and dominant landscape features of forests, mountains, and rivers. The local population is well acquainted with the rhythm of the seasons and has learned to organise accordingly. A significant portion of the Apennine population lives in small villages or isolated houses far from major urban centres. "**Working in rural areas**" means taking care of an extremely vast territory, dealing with various issues related to the unique context, and spending a lot of time outdoors.

The extensive territory necessitates long journeys, making home care, in some aspects, slower than in cities. Many nurses spend their entire work shifts inside their own cars, travelling through the mountains, heading to the patients' homes, and not returning to their base until near the end of their shift. While some patients are easily reachable because they live along main roads, many reside in isolated houses. Driving is an unavoidable aspect of the job:' I love driving, I am not afraid to drive in the snow, I feel safe, and in the end, I have no problems. But the car is a significant factor in our work…" (interview 5); "…look, I live it very serenely. I have to tell you, however, that I do not like driving. … Work is work; I take my car and go!" (interview 10). Home care nurses face an "increased" professional risk related to their work on the road: "Sometimes, if the road is very bad, I usually leave the car on the main road and then walk a part of the way". (interview 10); "It's also true that often you can't find traffic, but you can't even find the way to the patient's house! Sometimes, there is no road. I took a path in the wood and reached the patient's house. I did this on foot (interview 2). Unlike those working in hospitals, home care nurses must also consider the weather because they are exposed to various weather conditions in mountainous areas: "When it snows, for example, we leave early to do the blood draws, as always. Often, the snowploughs has not passed. The problem is that if it snows a lot, you can't figure out where the road is and where the field begins… hoping not to fall into the ditch!" (interview 3). However, the Apennine Mountains are rich in wonderful landscapes and breathtaking views. Nurses share a strong sense of love and belonging to the territory where they work every day: "I've seen huge deer, beautiful sunrises, very beautiful snowfalls, snow-capped mountains in the early morning, it's beautiful! You're always in touch with the wild nature!" (interview 9). An interesting aspect is the relationship that some nurses have with animals. Many patients' homes are inhabited by domestic animals, such as dogs and cats, which are often loyal companions for the elderly. Home care nurses must show respect for these companion animals, but sometimes they have to deal with unusual situations such as being chased by dogs, creative defensive measures (using their backpacks, bags, and boots), unexpected escape routes (jumping over fences and hedges to escape unfriendly dogs), and feline colonies attacking the nurse or her car. Sometimes, it is necessary to keep overly curious dogs away from wounds with a high risk of infection, or cats comfortably settled on urinary catheter kits. It's not to be underestimated that some nurses fear dogs and cats or have confirmed allergies to animal hair: "I'll also tell you that loving animals and our territory is almost a requirement to enter home care! After a short time, those who have problems with animals run away from home care. Because you go to people's homes, and you have to dress wounds or take blood samples while the dog wags its tail at you or barks at you…' (interview 7). The Apennine Mountains are also teeming with numerous wild animals that, more than ever, tend to approach areas inhabited by humans. It is customary for nurses to encounter deer, fallow deer, and wild boar during their journeys. In their view, having a regular life with mornings or afternoons of work contributes to making them "**healthcare professionals**". They have more time to dedicate themselves to their families. Balancing work and private life is not always easy, but home care allows them to do so naturally, without burdening the healthcare professional. Some nurses missed the organisation of hospital shifts. However, working half a day means having much more time for themselves, without being fatigued by too many hours of work or sleepless nights: "I am very happy and very lucky to have such a schedule. Compared to working nights, quality of life is significantly better. You can organise as

you want…" (interview 1); "And since I have been doing the daytime shift, I am much healthier. The quality of life is better." (interview 8).

Discussion

This study aimed to explore the perceptions regarding satisfaction, encountered difficulties, and possessed and required skills of home care nurses serving in the rural areas of Italy. Participants were experienced professionals with previous work experience in hospital departments or other private healthcare facilities. As highlighted in other studies, home care nurses enter patients' homes while respecting each individual's characteristics and understanding that not everyone is willing to receive care in the same way[28–30]. Sometimes, they must take a step back, allowing people to make decisions themselves. This can lead to frustration and a sense of powerlessness, which can be shared with the workgroup to receive necessary support. Peer support and collaboration with general practitioners are considered fundamental[6]. In a home care setting, nurses must display confidence, competence, and the capability to earn trust and professional respect[31–34]. At times, nurses may struggle to maintain the necessary emotional detachment required for their psychophysical well-being because providing care means empathising with patients' suffering and taking care of their needs[31,33,35–37]. To work effectively in rural areas, nurses require knowledge, skills, and abilities acquired through years of professional experience. In addition, they must adapt to various situations and find creative solutions to significant clinical problems[6]. Nurses working in rural areas have unique characteristics that distinguish them from their hospital colleagues[6]. Outside Italy, community healthcare is provided by highly qualified professionals with greater autonomy, responsibility, and advanced clinical skills compared to their hospital counterparts[38–46]. These competencies are acquired through post-basic university study programs[4,12], training Nurse Practitioners or Advanced Practice Nurses, which represent a solution to the shortage of family physicians in rural areas worldwide[12–14]. Although conflicts between physicians and advanced practice nurses (NPs or APNs) are common, the model appears to function well, fulfilling its purpose.

Our study results highlight the ideal or required characteristics that each professional should possess to work in home care: having a keen clinical eye and professional experience, being able to work independently while remaining humble, taking responsibility, collaborating with other professionals, being respectful, calm, and patient; building trust with people; adapting to various situations; being flexible; showing initiative and creativity; being organised; being in good health and physically fit; possessing a driver's licence and safe driving skills; and loving the Apennine territory and animals. Some of these attributes are personal inclinations, and cannot be acquired solely through years of work experience. This highlights the complexity of identifying motivated and capable individuals suitable for home care. Recruiting young, predisposed, and competent nurses with experience in specialised departments or private healthcare facilities is proposed to bring new strength and vitality to home care, fostering future innovation and change agents[3].

The interviewed nurses expressed satisfaction with their professional and personal lives thanks to a healthy lifestyle in a rural area, away from the city's hustle and bustle[8], and daytime work shifts[13], allowing for ample free time outside of work[8]. Throughout the interviews, it emerged that nurses held a deep affection for their profession. They are aware of the role they play in the Apennine community, which brings immense satisfaction and gratification[6]. The distance from large city hospitals and limited service offerings enable them to establish even stronger and lasting bonds with their patients[6,12,47].

The interviewed nurses viewed home nursing as a distinct form of care delivery, unique and marked by distinctive elements. Entering some homes demands utmost attention to protect their own health while carrying out public duties. Homes, especially in mountainous areas, often have numerous pets that interact with nurses in various ways, sometimes by biting bags, backpacks, or shoes[48-51]. Allergies to dog, cat, or other animal hair should not be overlooked, as these conditions can pose significant health risks to professionals[47–50]. Driving a company vehicle is no less dangerous than driving one's own car, and like any other motorist, home care nurses face the risk of accidents and other road-related hazards. Home care nurses are aware of their position within the health care system and take pride in it. Consequently, they accept the risks associated with working in rural areas[6].

Study limitations

The results of this study cannot be generalised to the entire population of Italian home care nurses in rural areas. Qualitative studies are closely tied to the location in which they are conducted, and the transferability of results depends on a careful analysis of the key context parameters. While the emerging results share common features with other studies in the literature, indicating that the experiences of home care nurses in rural areas are characterised by recurring and similar factors, it is undeniable that the described research was conducted in a unique environment that may have few parallels in other parts of the world.

Conclusions

Our results are in line with those reported in the international literature and suggest the importance of enhancing the provision of healthcare services at the territorial level, strengthening the network of primary care and services offered to citizens, and promoting the continuity of care.

Human resource managers should encourage the entry of young nurses into rural areas, even those with clinical experience, preferably those who belong to the Apennine Mountains or show a predisposition and special empathy for mountain populations [4]. Universities should promote post-basic training programs aimed at acquiring specific and advanced competencies related to clinical nursing practice in the community. Rural areas urgently require qualified professionals with greater autonomy and are capable of practising advanced care to protect the health of citizens. Autonomy and professional responsibility in the community are key to promoting health in advanced organizational contexts[3].

Conflict of interest

The authors declare no conflict of interest in conducting this study.

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